FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034678

Facility Name: THE LINCOLN HOME

Address: 150 N. 27TH STREET (Number) BELLEVILLE (City) 62223 (Zip Code)

County: SINCLAIR

Telephone Number: (618) 235-6600 **Fax #** (618) 235-7555

IDPA ID Number: 36-1237774001

Date of Initial License for Current Owners: 9/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) MARTIN J. WEISS

(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1

(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,692	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,940	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,632	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,925	1,925	8
9	SNF/PED					9
10	ICF	29,490	5,854		35,344	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,490	5,854	1,925	37,269	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 66.99%

D. How many bed-hold days during this year were paid by Public Aid? 73 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 1925

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	126,653	16,232	8,435	151,320		151,320	0	151,320			1
2	Food Purchase		138,363		138,363		138,363	(997)	137,366			2
3	Housekeeping	94,264	19,710	0	113,974		113,974	0	113,974			3
4	Laundry	37,071	16,035	1,105	54,211		54,211	0	54,211			4
5	Heat and Other Utilities			87,895	87,895		87,895	1,058	88,953			5
6	Maintenance	55,554	20,610	26,359	102,523		102,523	(3,822)	98,701			6
7	Other (specify):*			9,708	9,708		9,708	162	9,870			7
8	**TOTAL General Services**	313,542	210,950	133,502	657,994		657,994	(3,599)	654,395			8
	B. Health Care and Programs											
9	Medical Director			13,100	13,100		13,100	0	13,100			9
10	Nursing and Medical Records	998,628	53,353	64,543	1,116,524		1,116,524	5,168	1,121,692			10
10a	Therapy	0		2,909	2,909		2,909	0	2,909			10a
11	Activities	46,048	4,951	12,000	62,999		62,999	(10,977)	52,022			11
12	Social Services	51,611	65	0	51,676		51,676	0	51,676			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,096,287	58,369	92,552	1,247,208		1,247,208	(5,809)	1,241,399			16
	C. General Administration											
17	Administrative	65,737		0	65,737		65,737	20,662	86,399			17
18	Directors Fees			0				0				18
19	Professional Services			229,917	229,917		229,917	(194,404)	35,513			19
20	Dues, Fees, Subscriptions & Promotions			28,322	28,322		28,322	(14,199)	14,123			20
21	Clerical & General Office Expense	86,640	23,739	34,277	144,656		144,656	50,468	195,124			21
22	Employee Benefits & Payroll Taxes			239,513	239,513		239,513	0	239,513			22
23	Inservice Training & Education			1,534	1,534		1,534	114	1,648			23
24	Travel and Seminar			16,216	16,216		16,216	21,055	37,271			24
25	Other Admin. Staff Transportation			8,033	8,033		8,033	0	8,033			25
26	Insurance-Prop.Liab.Malpractice			65,370	65,370		65,370	1,867	67,237			26
27	Other (specify):*			0				14,190	14,190			27
28	**TOTAL General Administration**	152,377	23,739	623,182	799,298		799,298	(100,247)	699,051			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,562,206	293,058	849,236	2,704,500		2,704,500	(109,655)	2,594,845			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,756	22,756		22,756	63,670	86,426			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			10,872	10,872		10,872	220,233	231,105			32
33	Real Estate Taxes			26,280	26,280		26,280	0	26,280			33
34	Rent-Facility & Grounds			318,576	318,576		318,576	(307,961)	10,615			34
35	Rent-Equipment & Vehicles			8,032	8,032		8,032	13,213	21,245			35
36	Other (specify):*							0				36
37	TOTAL Ownership			386,516	386,516		386,516	(10,845)	375,671			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		50,761	108,506	159,267		159,267	0	159,267			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			83,448	83,448		83,448	0	83,448			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		50,761	191,954	242,715		242,715		242,715			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,562,206	343,819	1,427,706	3,333,731	0	3,333,731	(120,500)	3,213,231			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(586)	30		9
10	Interest and Other Investment Income	(5,933)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(997)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(844)	21		18
19	Entertainment	0	20		19
20	Contributions	(2,625)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(12,015)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	0	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (23,000)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(97,500)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (97,500)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (120,500)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS **Page 5A**

Facility Name THE LINCOLN HOME
ID# 0026678
Report Period Beginning: 01/01/2009
Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Adj. Summary
	The information listed in B13 thru G43 is from Page 5.			
1	**Day Care**	0	0	**Line 1** 0
2	**Other Care for Outpatients**	0	0	**Line 2** (98)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3** 0
4	**Non-Patient Meals**	0	2	**Line 4** 0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5** 0
6	**Rented Facility Space**	0	34	**Line 6** 0
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7** 0
8	**Laundry for Non-Patients**	0	4	**Line 8** (98)
9	**Non-Straightline Depreciation**	(586)	30	**Line 9** 0
10	**Interest and Other Investment Income**	(5,933)	32	**Line 10** 0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 10a** 0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11** 0
13	**Sales Tax**	(907)	2	**Line 12** 0
14	**Non-Care Related Interest**	0	32	**Line 13** 0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14** 0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15** 0
17	**Non-Care Related Fees**	0	20	**Line 16** 0
18	**Fines and Penalties**	(844)	21	**Line 17** 0
19	**Entertainment**	0	20	**Line 18** 0
20	**Contributions**	(2,625)	20	**Line 19** 0
21	**Owner or Key-Man Insurance**	0	22	**Line 20** (14,640)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21** (841)
23	**Malpractice Insurance for Individuals**	0	26	**Line 22** 0
24	**Bad Debt**	0	27	**Line 23** 0
25	**Fund Raising, Advertising and Promotional**	(12,015)	20	**Line 24** 0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25** 0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26** 0
28	**Yellow Page Advertising**	0	20	**Line 27** 0
29	**Non-Paid Workers**	0	0	**Line 28** (15,498)
30	**Donated Goods**	0	0	**Line 29** (16,441)
31	**Amortization Expense**	0	0	**Line 30** (586)
32				**Line 31** 0
33				**Line 32** (5,933)
34				**Line 33** 0
35				**Line 34** 0
36				**Line 35** 0
37				**Line 36** 0
38				**Line 37** (9,749)
39				**Line 38** 0
40				**Line 39** 0
41				**Line 40** 0
42				**Line 41** 0
43				**Line 42** 0
44				**Line 43** 0
45				**Line 44** 0
46				**Line 45** (53,099)
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Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(997)	0	0	0	0	0	0	0	0	0	0	(997)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,058	0	0	0	0	0	0	0	0	0	1,058	5
6	Maintenance	0	(3,822)	0	0	0	0	0	0	0	0	0	(3,822)	6
7	Other (specify):*	0	162	0	0	0	0	0	0	0	0	0	162	7
8	**TOTAL General Services**	(997)	(2,602)	0	0	0	0	0	0	0	0	0	(3,599)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,168	0	0	0	0	0	0	0	0	0	5,168	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(10,977)	0	0	0	0	0	0	0	0	0	(10,977)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	(5,809)	0	0	0	0	0	0	0	0	0	(5,809)	16
	C. General Administration													
17	Administrative	0	20,662	0	0	0	0	0	0	0	0	0	20,662	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(194,404)	0	0	0	0	0	0	0	0	0	(194,404)	19
20	Fees, Subscriptions & Promotions	(14,640)	441	0	0	0	0	0	0	0	0	0	(14,199)	20
21	Clerical & General Office Expenses	(844)	51,312	0	0	0	0	0	0	0	0	0	50,468	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	114	0	0	0	0	0	0	0	0	114	23
24	Travel and Seminar	0	0	21,055	0	0	0	0	0	0	0	0	21,055	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,867	0	0	0	0	0	0	0	0	1,867	26
27	Other (specify):*	0	0	14,190	0	0	0	0	0	0	0	0	14,190	27
28	**TOTAL General Administration**	(15,484)	(121,989)	37,226	0	0	0	0	0	0	0	0	(100,247)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,481)	(130,400)	37,226	0	0	0	0	0	0	0	0	(109,655)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(586)	0	404	63,852	0	0	0	0	0	0	0	63,670	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,933)	0	83	226,083	0	0	0	0	0	0	0	220,233	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	10,615	(318,576)	0	0	0	0	0	0	0	(307,961)	34
35	Rent-Equipment & Vehicles	0	0	13,213	0	0	0	0	0	0	0	0	13,213	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,519)	0	24,315	(28,641)	0	0	0	0	0	0	0	(10,845)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(23,000)	(130,400)	61,541	(28,641)	0	0	0	0	0	0	0	(120,500)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe THE LINCOLN HOME # 0024678 Report Period Beginning 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		SEE ATTACHED LIST				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	Amount	4 Name of Related Organization	5 Cost to Related Organization Percent of Ownership	Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1 V	6	MAINTENANCE CONSULT	$ 14,760	MAVIN ENTERPRISES LTI	6	6	(14,760)	1	-14760
2 V	10	PSYCHO/SOCIAL CONSULT	12,000				(12,000)	2	-12000
3 V	11	ACTIVITIES CONSULT	12,000				(12,000)	3	-12000
4 V	19	ADMIN/BK&P FEES	196,440				(196,440)	4	-196440
5 V	5	ELECTRICITY				1,058	1,058	5	1058
6 V	6	MAINTENANCE				10,938	10,938	6	10938
7 V	7	SCAVENGER				162	162	7	162
8 V	10	PSYCHO-SOCIAL CONSULT				17,168	17,168	8	17168
9 V	11	ACTIVITIES CONSULT				1,023	1,023	9	1023
10 V	17	ADMIN. SALARIES/MGMT				20,662	20,662	10	20662
11 V	19	PROFESSIONAL FEES				2,036	2,036	11	2036
12 V	20	ADVERTISING				441	441	12	441
13 V	21	TOTAL OFFICE				51,312	51,312	13	51312
14 Total			$ 235,200		$	104,800	$ * (130,400)	14	

* Total must agree with the amount recorded on line 24 of Schedule V

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	23	SEMINARS	$	MEVIN ENTERPRISES LTD		$ 114	$ 114	15	114
16	V	24	TRAVEL				21,055	21,055	16	21055
17	V	26	INSURANCE				1,867	1,867	17	1867
18	V	27	EMPLOYEE BENEFITS				14,190	14,190	18	14190
19	V	30	DEPRECIATION (SL)				404	404	19	404
20	V	32	INTEREST				83	83	20	83
21	V	34	OFFICE RENT				10,615	10,615	21	10615
22	V	35	EQUIPMENT RENT				13,213	13,213	22	13213
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 61,541	$ * 61,541	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	34	RENT	$ 318,576	LINCOLN ASSOCIATES LTD		$	$ (318,576)	15	-318576
16	V	30	DEPRECIATION				63,852	63,852	16	63852
17	V	32	INTEREST EXPENSE				226,083	226,083	17	226083
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 318,576			$ 289,935	$ * (28,641)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1					SEE ATTACHED				$		1
2					SCHEDULE						2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAVIN ENTERPRISES LTD
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY	PATIENT DAYS	167,662	7	$ 4,758	$	37,269	$ 1,058	1
2	6	MAINTENANCE	PATIENT DAYS	167,662	7	49,208		37,269	10,938	2
3	7	SCAVENGER	PATIENT DAYS	167,662	7	728		37,269	162	3
4	10	PSYCHO-SOCIAL CONSUL	PATIENT DAYS	167,662	7	77,233		37,269	17,168	4
5	11	ACTIVITIES CONSULT	PATIENT DAYS	167,662	7	4,601		37,269	1,023	5
6	17	ADMIN. SALARIES/MGMT	PATIENT DAYS	167,662	7	92,950	92,950	37,269	20,662	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	167,662	7	9,158		37,269	2,036	7
8	20	ADVERTISING	PATIENT DAYS	167,662	7	1,984		37,269	441	8
9	21	TOTAL OFFICE	PATIENT DAYS	167,662	7	230,835	145,432	37,269	51,312	9
10	23	SEMINARS	PATIENT DAYS	167,662	7	514		37,269	114	10
11	24	TRAVEL	PATIENT DAYS	167,662	7	94,720		37,269	21,055	11
12	26	INSURANCE	PATIENT DAYS	167,662	7	8,400		37,269	1,867	12
13	27	EMPLOYEE BENEFITS	PATIENT DAYS	167,662	7	63,836		37,269	14,190	13
14	30	DEPRECIATION (SL)	PATIENT DAYS	167,662	7	1,817		37,269	404	14
15	32	INTEREST	PATIENT DAYS	167,662	7	375		37,269	83	15
16	34	OFFICE RENT	PATIENT DAYS	167,662	7	47,754		37,269	10,615	16
17	35	EQUIPMENT RENT	PATIENT DAYS	167,662	7	59,442		37,269	13,213	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 748,313	$ 238,382		$ 166,341	25

Print Preview

Print Page 8A

STATE OF ILLINOIS

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN ASSOCIATES LTD
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COST	1	1	$ 63,852	$	1	$ 63,852	1
2	32	INTEREST EXPENSE	DIRECT COST	1	1	226,083		1	226,083	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 289,935	$		$ 289,935	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

STATE OF ILLINOIS

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	MEVIN ALLOCATION										83	5
	Working Capital											
6	MELLON BANK		X	WASHER, DRYERS							2,053	6
7	SHARHOLDERS	X		WORKING CAPITAL	DEMAND	1998	146,981	146,981	DEMAND	6.000	8,819	7
8												8
9	TOTAL Facility Related						$ 146,981	$ 146,981			$ 10,955	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 146,981	$ 146,981			$ 10,955	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	23,424	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	24,852	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,428	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	24,852	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	26,280	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	21,128	8
	1996	21,255	9
	1997	22,469	10
	1998	23,424	11
	1999	24,852	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,241 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 0 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 148,649	1
2					2
3	TOTALS			$ 148,649	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	152		1988		$ 2,011,351	$ 63,852	31.5	$ 63,852	$	$ 759,317	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	VARIOUS			1990	11,158	354	31.5	354		9,980	9
10	VARIOUS			1993	6,676	171	39	171		2,069	10
11	VARIOUS			1994	7,797	200	39	200		2,258	11
12	VARIOUS			1995	13,072	335	39	335		2,907	12
13	CARPET			1996	907	23	39	23		144	13
14	BILLBOARD			1996	900	23	39	23		147	14
15	SMOKE DETECTORS			1996	602	15	39	15		100	15
16	PARKING LOT			1996	8,006	205	39	205		1,410	16
17	AWNING			1996	905	23	39	23		162	17
18	CARPETING			1996	1,512	39	39	39		287	18
19	DOOR LOCKS			1997	2,100	54	39	54		274	19
20	WALL PAPER			1997	2,012	52	39	52		274	20
21	HANDRAIL			1997	3,217	82	39	82		365	21
22	FIRE ALARM SYSTEM			1998	11,636	298	39	298		887	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION			1998	9,227	237	39	237		705	23
24	PAINTING/WALLPAPERING			1998	2,988	77	39	77		229	24
25	REPLACE PVC PIPE IN BASEMENT			1998	1,074	28	39	28		83	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUAR			1999	6,144	80	39	80		160	26
27	INSTALLED A NEW DURO-LAST ROOF			1999	56,400	722	39	722		1,444	27
28	WALLPAPER			2000	14,896	198	20	745	547	745	28
29	SEWER LINE REPAIR			2000	11,743	144	27.5	144		144	29
30	AIR CONDITIONING UNITS			2000	8,848	108	27.5	108		108	30
31	CONDENSING UNIT ON FREEZER			2000	2,693	36	27.5	36		36	31
32	NEW NURSES STATION			2000	20,379	271	27.5	271		271	32
33	FIRE ALARM SYSTEM			2000	1,826	24	27.5	24		24	33
34	HOT WATER SYSTEM			2000	3,849	782	27.5	782		782	34
35	TILED FLOORS			2000	54,185	704	20	2,709	2,005	704	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 69,137		$ 71,689	$ 2,552	$ 786,016	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	REMODELING OF BATHROOMS			2000	18,490	235	27.5	235		235	9
10	INSTALLED A/C UNITS FOR RESIDENT ROOMS			2000	13,369	2,658	27.5	2,658		2,658	10
11											11
12											12
13											13
14											14
15											15
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 2,893		$ 2,893	$	$ 2,893	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 95,694	$ 8,736	$ 9,622	$ 886	5-10	$ 51,065	37
38	Current Year Purchases	36,351	5,842	1,818	(4,024)	10	1,818	38
39	Fully Depreciated Assets	17,154					17,154	39
40	MAVIN ALLOCATION		404	404				40
41	TOTALS	$ 149,199	$ 14,982	$ 11,844	$ (3,138)		$ 70,037	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$ 19,738	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 106,750	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 86,426	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (586)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 858,946	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the curre
    rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipm $ 1,290 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		1997 FORD WAGON	$ 500.00	$ 3,366	17
18		2000 DODGE RAM	650.00	3,376	18
19					19
20					20
21	TOTAL		$ ######	$ 6,742	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 40,087	$		$ 40,087	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				2,952			2,952	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				65,467			65,467	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					39,246		39,246	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	RADIOLOGY Other (specify): MEDICAL SUPPLI	39-2 39-2					5,486 6,029			5,486 6,029	13
14	TOTAL				$		$ 120,021	$ 39,246		$ 159,267	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 56,140	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,015,162		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,591		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	594,805		8
9	Other(specify): REAL ESTATE ESCROW DEI	10,480		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,700,178	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	284,625		15
16	Equipment, at Historical Cost	161,186		16
17	Accumulated Depreciation (book methods)	(126,012)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 319,799	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,019,977	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,959,824	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,383		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,381		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,241		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,852		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,058,681	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,058,681	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (38,704)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,019,977	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (144,613)	1
2	Restatements (describe):		2
3	PRIOR YEAR CLOSING ADJUSTMENT	(816)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (145,429)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	106,725	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 106,725	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (38,704)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,391,353	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,391,353	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	43,170	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 43,170	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,933	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 5,933	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 3,440,456	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 657,994	31
32	Health Care	1,247,208	32
33	General Administration	799,298	33
	B. Capital Expense		
34	Ownership	386,516	34
	C. Ancillary Expense		
35	Special Cost Centers	159,267	35
36	Provider Participation Fee	83,448	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,333,731	40
41	**Income before Income Taxes (line 30 minus line 40)****	106,725	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 106,725	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,528	4,019	$ 84,712	$ 21.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,745	3,971	71,438	17.99	3
4	Licensed Practical Nurses	21,938	23,666	348,368	14.72	4
5	Nurse Aides & Orderlies	49,164	52,669	399,228	7.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,330	5,602	46,048	8.22	10
11	Social Service Workers	4,868	5,245	51,611	9.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,349	18,489	126,653	6.85	15
16	Dishwashers					16
17	Maintenance Workers	4,873	5,326	55,554	10.43	17
18	Housekeepers	14,501	15,179	94,264	6.21	18
19	Laundry	6,192	6,573	37,071	5.64	19
20	Administrator	2,000	2,297	65,737	28.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,657	8,486	86,640	10.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify SEE ATTACHE	6,181	6,611	94,882	14.35	33
34	TOTAL (lines 1 - 33)	147,326	158,133	$ 1,562,206 *	$ 9.88	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,435	1-3	35
36	Medical Director	O	13,100	9-3	36
37	Medical Records Consultant	N	595	10-3	37
38	Nurse Consultant	T	31,712	10-3	38
39	Pharmacist Consultant	H	1,200	10-3	39
40	Physical Therapy Consultant	L	2,909	10a-3	40
41	Occupational Therapy Consulta	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	12,000	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL CONSULTANT		19,930	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 89,881		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 280	10-3	50
51	Licensed Practical Nurses	324	9,957	10-3	51
52	Nurse Aides	32	573	10-3	52
53	TOTAL (lines 50 - 52)	364	$ 10,810		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BOBI L. SMITH	ADMIN	0.00%	$ 65,737
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,737

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK, BOKOR	ACCOUNTING FEES	$ 4,100
GARY A. WEINTRAUB	LEGAL FEES	7,100
MEVIN ENTERPRISES	BOOKKEEPING SERVICI	196,440
NURSING CARE SYSTEM	DATA PROCESSING	7,904
ALPHA DATA SERVICE	DATA PROCESSING	3,346
PEAK COMPUTER SYSTEM	DATA PROCESSING	210
SHARON HAUGH	MEDICARE CONSULT	3,000
RICHARD PEELO	MEDICARE CONSULT	3,000
RHOADS REIMBURSEMENT	MEDICARE CONSULT	3,000
PERSONNEL PLANNERS	UC CONSULTANT	1,817
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 229,917

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,740
Unemployment Compensation Insurance	38,475
FICA Taxes	122,244
Employee Health Insurance	42,794
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	2,260
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 239,513

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	6,819
Health Care Worker Background Chec	384
(Indicate # of checks perform 32)	
ADV & PROMO/MARKETING	12,015
DUES & SUBSCRIPTIONS	5,951
LICENSES & PERMITS	328
TRUST FEES, CONTRIBUTIONS,etc.	2,625
MGMT CO ALLOCATION	441
LESS TRUST FEES, CONTRIB, etc.	(2,625)
Less: Public Relations Expense	( )
Non-allowable advertising	(12,015)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,123

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,216
TRAVEL	21,055
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 37,271

* Attach copy of IMRF notifications

**See instructions.

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